

<i>SERFF Tracking Number:</i>	<i>AMAL-126854778</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Amalgamated Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47754</i>
<i>Company Tracking Number:</i>	<i>AMINDDI-10</i>		
<i>TOI:</i>	<i>H111 Individual Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H111.006 Short Term - Related to marketing with employer or association groups</i>
<i>Product Name:</i>	<i>Individual Disability Income</i>		
<i>Project Name/Number:</i>	<i>Individual Disability Income/AMINDDI-10</i>		

Filing at a Glance

Company: Amalgamated Life Insurance Company

Product Name: Individual Disability Income SERFF Tr Num: AMAL-126854778 State: Arkansas

TOI: H111 Individual Health - Disability Income SERFF Status: Closed-Approved- State Tr Num: 47754
Closed

Sub-TOI: H111.006 Short Term - Related to Co Tr Num: AMINDDI-10 State Status: Approved-Closed
marketing with employer or association groups

Filing Type: Form

Author: Claire Pizzuti

Date Submitted: 01/20/2011

Reviewer(s): Rosalind Minor

Disposition Date: 01/21/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Individual Disability Income

Project Number: AMINDDI-10

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: This filing is pending approval in our domicile state of NY.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 01/21/2011

State Status Changed: 01/21/2011

Deemer Date:

Created By: Claire Pizzuti

Submitted By: Claire Pizzuti

Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your review and approval are the following forms. These forms are new and will not replace any other previously filed or approved forms.

Form AMINDDI-10 (AR), Guaranteed Renewable Disability Income Insurance Policy provides income protection to an individual insured upon disability resulting from bodily injury, sickness or pregnancy.

Bracketed text within the policy form indicates variability.

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This policy is intended to be marketed primarily to members of labor unions and labor organizations, to associations and traditional employer groups. This marketing will be conducted in the workplace.

The following optional riders will be used with the policy, if chosen, at issue.

Form AMINDDI-PTR-10 (AR), Physical Therapy Benefit Rider pays \$50 for each of up to ten physical therapy sessions attended by a claimant receiving disability benefits under the base policy.

Form AMINDDI-CATLOSSR-10 (AR), Catastrophic Loss Rider, pays a Catastrophic Loss Monthly Benefit if the Insured: (1) has a Catastrophic Loss (due to an injury or sickness, the Insured is continuously not able to perform two or more Activities of Daily Living), (2) satisfies the Catastrophic Loss Elimination Period (90 days or 180 days), and (3) is under the regular care and attendance of a physician. The Catastrophic Loss Lifetime Maximum Periods are: 12, 24, or 36 months.

Form AMINDDI-CONTDIR-10 (AR), Continuing Disability Benefit Rider provides a Continuing Disability Monthly Benefit (\$100 - \$600) when an Insured is totally disabled as the result of an accident or sickness. Benefits are paid after the Insured has satisfied the Continuing Disability Elimination Period (180 days), for a time up to the Continuing Disability Maximum Benefit Period (6 months or 18 months). The benefits of this Rider are paid in addition to any Monthly Disability Benefit provided in the base policy. This Rider is only available with base policies that have a Maximum Disability Benefit Period of 12 months or more.

Form AMINDDI-STRIKER-10 (AR), Strike Waiver of Premium Rider waives premiums for up to 6 months during a lawful primary strike.

Application form AMINDDI-APP-10 (AR) will be used when the application is taken in a face-to-face interview. A description of our electronic application and signature procedures is attached under the Supporting Documentation tab.

The forms have been completed in John Doe fashion and are subject to minor modification in paper size and stock, ink, logo, border and adaptation to electronic printing.

Company and Contact

Filing Contact Information

Claire Pizzuti, Policy Form Compliance Manager	cpizzuti@amalgamatedlife.com
333 Westchester Avenue	914-367-5581 [Phone]

SERFF Tracking Number: AMAL-126854778 State: Arkansas
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 Project Name/Number: Individual Disability Income/AMINDDI-10

White Plains, NY 10604 914-367-4115 [FAX]

Filing Company Information

Amalgamated Life Insurance Company CoCode: 60216 State of Domicile: New York
 333 Westchester Ave. Group Code: Company Type:
 White Plains, NY 10604 Group Name: State ID Number:
 (914) 367-5581 ext. [Phone] FEIN Number: 13-5501223

Filing Fees

Fee Required? Yes
 Fee Amount: \$300.00
 Retaliatory? No
 Fee Explanation: 6 forms @\$50 each
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Amalgamated Life Insurance Company	\$300.00	01/20/2011	43942872

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/21/2011	01/21/2011

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Disposition

Disposition Date: 01/21/2011

Implementation Date:

Status: Approved-Closed

Comment:

This submission is being approved with the understanding that in order to market the product through an Association, that association must have our Department's prior approval. Refer to ACA 23-86-106 (2)(A) and (C)(i).

Rate data does NOT apply to filing.

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Company Tracking Number: AMINDDI-10

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Product Name: Individual Disability Income

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	No
Supporting Document	Application	Approved-Closed	No
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	No
Form	Disability Income Insurance Policy	Approved-Closed	No
Form	Catastrophic Loss Rider	Approved-Closed	No
Form	Physical Therapy Benefit Rider	Approved-Closed	No
Form	Continuing Disability Benefit Rider	Approved-Closed	No
Form	Strike Waiver of Premium Rider	Approved-Closed	No
Form	Application	Approved-Closed	No
Rate	Individual Disability Income Rates	Approved-Closed	No

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Form Schedule

Lead Form Number: AMINDDI-10

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Status						
Approved-Closed 01/21/2011	AMINDDI-10 (AR)	Policy/Cont Disability Income ract/Fratern Insurance Policy al Certificate	Initial		46.600	AMINDDI-10 (AR) policy.pdf
Approved-Closed 01/21/2011	AMINDDI-CATLOSS R-10 (AR)	Policy/Cont Catastrophic Loss ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		46.700	AMINDDI-CATLOSSR- 10 (AR) Catastrophic Rider.pdf
Approved-Closed 01/21/2011	AMINDDI-PTR-10 (AR)	Policy/Cont Physical Therapy ract/Fratern Benefit Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		46.900	AMINDDI-PTR-10 (AR) Physical Therapy Rider.pdf
Approved-Closed 01/21/2011	AMINDDI-CONTDIR- 10 (AR)	Policy/Cont Continuing Disability ract/Fratern Benefit Rider al Certificate: Amendmen t, Insert Page, Endorseme	Initial		51.900	AMINDDI-CONTDIR-10 (AR) Continuing Dis Rider.pdf

AMALGAMATED LIFE INSURANCE COMPANY
[333 WESTCHESTER AVENUE WHITE PLAINS, NEW YORK 10604]

DISABILITY INCOME INSURANCE POLICY

CONSIDERATION: We promise to insure You for the benefits described in this Policy. We make this promise in consideration of the application for this Policy and the payment of the premium. Your coverage under this Policy is in force as of the Policy Effective Date shown on the Policy Specification Page.

This Policy is a legal contract between You and Amalgamated Life Insurance Company. No agent may change this Policy or waive any of its provisions.

YOUR RIGHT TO EXAMINE THIS POLICY: It is important to Us that You are satisfied with this Policy. If You are not satisfied, send it back to Us within thirty (30) days after You have received it. We will send back Your money and the Policy will be considered to have never been in force. If you return the Policy, please note in writing: "This Policy is returned for cancellation and refund of premium."

GUARANTEED RENEWABLE TO THE POLICY ANNIVERSARY ON OR NEXT FOLLOWING YOUR 72ND BIRTHDAY. We guarantee You can keep this policy in force to the Policy Anniversary on or next following Your 72nd birthday, as long as You pay the required premiums when due, subject to the Grace Period allowed.

RIGHT TO CHANGE PREMIUM: We may change the premium rate, but only if the New York Superintendent of Insurance approves the rate. We will then change the rate for all policies of this class. While this Policy is in force, no change will be made in Your class because of age, sex, or physical condition of any Insured Person(s). "Class" means all policies of this form number and premium classification issued or issued for delivery in New York. If the premium rate changes, We will notify You in writing at Your last known address at least thirty-one (31) days before the change becomes effective.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION: We based Our decision to issue this policy on the information in Your application. Please carefully read Your application attached to this Policy. If You find any information shown is not correct or complete, please inform Us immediately. Incorrect information can result in the denial of a claim or termination of this Policy.

This policy is signed for Amalgamated Life Insurance Company.

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President

GUARANTEED RENEWABLE DISABILITY INCOME INSURANCE POLICY

NON-PARTICIPATING

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POLICY SPECIFICATION PAGE

BENEFITS

PREMIUM

COVERAGE TYPE: [OFF-THE-JOB COVERAGE]
MONTHLY DISABILITY BENEFIT: [\$1,000.00]

[\$484.10]

MAXIMUM DISABILITY BENEFIT PERIOD:

ACCIDENT	[24 Months]
SICKNESS	[24 Months]

ELIMINATION PERIOD:

ACCIDENT	[14 DAYS]
SICKNESS	[14 DAYS]

PRE-EXISTING LIMITATION PERIOD: [12 MONTHS]

OPTIONAL RIDERS

[PHYSICAL THERAPY BENEFIT RIDER

[\$9.68]]

[CATASTROPHIC LOSS RIDER

[\$15.70]

CATASTROPHIC LOSS MONTHLY BENEFIT	[\$1,000.00]
CATASTROPHIC LOSS ELIMINATION PERIOD	[90 DAYS]
CATASTROPHIC LOSS LIFETIME MAXIMUM PERIOD	[24 MONTHS]
CATASTROPHIC LOSS PRE-EXISTING LIMITATION PERIOD	[12 MONTHS]

[CONTINUING DISABILITY BENEFIT RIDER

[\$48.41]

CONTINUING DISABILITY MONTHLY BENEFIT	[\$100.00]
CONTINUING DISABILITY ELIMINATION PERIOD	[180 DAYS]
CONTINUING DISABILITY MAXIMUM BENEFIT PERIOD	[6 MONTHS]

[STRIKE WAIVER OF PREMIUM RIDER

[\$11.16]]

PREMIUMS IF PAID:

	ONCE A YEAR	TWICE A YEAR	FOUR TIMES A YEAR	MONTHLY SPECIAL BILL
	[\$569.05]	[\$295.91]	[\$147.95]	[\$49.79]
PER YEAR	[\$569.05]	[\$591.82]	[\$591.80]	[\$597.48]

DISABILITY INCOME POLICY

INSURED:	[JOHN DOE]
EFFECTIVE DATE:	[01/01/2010]
ISSUE AGE:	[35]

POLICY NUMBER [12345]
[EMPLOYER NAME] [ABC UNION]

DEFINITIONS

ACCIDENT OR ACCIDENTAL INJURY means an injury that is independent of any Sickness; results in a Total Disability that begins after the Effective Date of this Policy and while your coverage is in force; and that begins within 90 days of the date of the accident.

ACTIVE WORK and ACTIVELY AT WORK means You are performing the Material And Substantial Duties of Your Own Occupation at your employer's usual place of business.

BASIC MONTHLY EARNINGS means 1/12th of your gross annual income or if your salary is solely or partially based on commissioned sales, bonus or overtime earnings, it means 1/24th of the proceeding 24 month's salary.

COMPLICATIONS OF PREGNANCY means (1) conditions requiring hospital stays (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and (2) nonelective caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

EFFECTIVE DATE means the date on which this coverage shall begin. Coverage begins at 11:59 P.M. on the date the application is signed by You, provided the Company has approved the coverage applied for and has received the necessary policy premiums.

ELIMINATION PERIOD means a period of consecutive days You must be continuously Totally Disabled before Monthly Disability Benefits become payable to You. No Monthly Disability Benefits are payable during the Elimination Period. The duration of the Elimination Period is shown in the Policy Specification Page. The Elimination Period begins on the first day of Total Disability occurring after the Effective Date of this Policy.

HOSPITAL means an institution that is run for the care and treatment of sick or injured persons as in-patients and which, on its premises or in facilities available to the hospital on a pre-arranged basis, meets fully every one of the following requirements:

1. is operated in accordance with the laws pertaining to hospitals in the jurisdiction in which it is located;
2. is under the supervision of a medical staff and has one or more physicians available at all times;
3. provides 24 hours a day service by registered graduate nurses (RN's); and
4. is not, other than incidentally, a place for the aged, a place for the mentally ill, or a nursing convalescent home. You will not be considered hospital confined if You are in a special unit used as a nursing, rest, or convalescent home.

INJURY means an accidental bodily injury that causes a loss or disability. The Loss must be a direct result of a bodily injury that occurs while Your insurance is in force and is independent of all other causes. The loss or disability must commence within 90 days of the accident; otherwise, it will be considered a sickness.

INSURED means the person named in the Policy.

MATERIAL AND SUBSTANTIAL DUTIES means the essential tasks, functions and operations generally required by those engaged in a particular occupation.

MAXIMUM DISABILITY BENEFIT PERIOD means the longest period for which Monthly Disability Benefits are payable for any one period of Total Disability, whether from one or more causes. The Maximum Disability Benefit Period begins at the end of the Elimination Period. No Monthly Disability Benefits are ever payable after the end of the Maximum Disability Benefit Period, even if You are still Totally Disabled.

DEFINITIONS (Continued)

MENTAL AND NERVOUS DISORDERS means any mental, emotional, behavioral, psychological, cognitive, personality, mood, or stress-related disease, disorder or dysfunction of any kind including, but not limited to, neurosis, psychoneurosis, psychopathy and psychosis. The term Mental or Nervous Disorder does not apply to dementia, if due to stroke, trauma, viral infection, Alzheimer's disease or other such conditions not listed above which are not usually treated using psychology, psychotropic drugs or other similar modalities.

MONTHLY DISABILITY BENEFIT means the monthly benefit payable to You under the terms of the Policy. Your Benefit is shown on the Policy Specification Page.

OWN OCCUPATION means any employment, business, trade, profession or vocation that involves Material and Substantial Duties of the same nature and character as the regular employment which You were routinely performing when Your Total Disability began. Your Own Occupation is not limited to Your job with Your employer.

PARTIALLY DISABLED means that due to a Sickness or Injury:

1. You are able to perform some but not all of the material and substantial duties of your occupation; or
2. You are able to work less than the standard number of hours you worked prior to the start of your Total Disability.

To be considered as Partially Disabled, You must first be Totally Disabled through the entire Elimination Period and have received at least one full Monthly Disability Benefit.

PHYSICIAN means a duly licensed practitioner of the healing arts acting within the scope of such license to treat Accidental Injuries or Sickness that results in Total Disability. A Physician cannot be You or anyone related to You by blood or marriage, a business or professional partner, or any person who has a financial affiliation or business interest with You.

POLICY means the legal contract between You and Us. The Policy, any application(s), the Policy Specification and any attached papers that We call Riders, amendments or endorsements make up the entire contract between You and Us.

PRE-EXISTING CONDITION means an Injury or Sickness for which, during a twelve-month period immediately preceding the Effective Date of this Policy, You have received a diagnosis or advice from a Physician and received treatment, incurred medical expenses or taken prescription drugs. The term Pre-Existing Condition shall also include any condition which is related to any such Injury or Sickness.

PRE-EXISTING LIMITATION PERIOD means the period of time (as shown on the Policy Specification Page) during which no benefits are payable for a Pre-Existing Condition.

RECURRENT DISABILITY means You become disabled, cease to be disabled, and then become disabled again for the same condition or a related condition. Recurrent Disability will be considered part of the original disability unless You return to Active Work for at least 90 consecutive days between the two periods of disability.

REGULAR CARE AND ATTENDANCE means that while you are Totally Disabled or Partially Disabled, You are under the care of a Physician at least once a month. We may waive this requirement if We determine that ongoing documentation of medical care is unnecessary.

SICKNESS means a sickness or disease that causes a loss or disability commencing while Your insurance is in force.

TERMINAL ILLNESS means a sickness for which a Physician has certified that You have a life expectancy of no more than 12 months.

DEFINITIONS (continued)

TOTALLY DISABLED OR TOTAL DISABILITY means that You are under the Regular Care and Attendance of a Physician and that for the first 24 months of Total Disability, You are unable to perform the Material and Substantial Duties of Your Own Occupation due to Sickness or Injury; and You are not engaged in any other occupation. After 24 months of disability, (if applicable), You are unable to perform the Material and Substantial Duties of any occupation for which You are reasonably qualified by education, training, or experience; and You are not engaged in any other occupation. If you are unemployed when You become Totally Disabled, We will pay the Monthly Disability Benefit Amount as long as you are under the Regular Care and Attendance of a Physician and unable to perform the Material and Substantial Duties of any occupation for which You are reasonably qualified by education, training, or experience.

YOU AND YOUR means the Insured named in the Policy.

WE, US OR OUR means Amalgamated Life Insurance Company.

DISABILITY BENEFITS

MONTHLY DISABILITY BENEFIT - A Monthly Disability Benefit will be paid for each month that You are Totally Disabled as defined in this Policy. The Total Disability must:

1. be due to an Accident or Sickness as defined in this Policy;
2. begin while coverage under this policy is in force; and
3. continue longer than the Elimination Period shown on the Policy Specification Page.

During the period of Total Disability You must be under the Regular Care and Attendance of a Physician.

We will pay a Monthly Disability Benefit for each period of Total Disability that continues beyond the Elimination Period. We will not pay benefits beyond the Maximum Disability Benefit Period shown on the Policy Specification Page. If any Monthly Disability Benefit is to be paid for less than a full month, the amount of benefit will be reduced pro-rata on the basis that one day's benefit equals 1/30th of the Monthly Disability Benefit. A Monthly Disability Benefit will be paid for only one disability when more than one disability exists at the same time; or a disability results from two or more causes.

Total Disability will be deemed to have commenced on the date You first received treatment from a Physician following continuous cessation of work.

PARTIAL DISABILITY BENEFIT - A Partial Disability Benefit will be paid if you become Partially Disabled due to a covered Accident or Sickness. To be considered as Partially Disabled, You must first be Totally Disabled through the entire Elimination Period and have received at least one full Monthly Disability Benefit. The Partial Disability Benefit will begin on the first day following cessation of Total Disability, subject to the following conditions:

1. The Partial Disability must be the result of the same Accident or Sickness which caused Total Disability; and
2. Partial Disability Benefits will be payable for a maximum of six consecutive months. The combined period of time for which benefits are payable for Total Disability and Partial Disability may not exceed the Maximum Disability Benefit Period as shown on the Policy Specification Page.

The Partial Disability Benefit will be equal to 50% of the Monthly Disability Benefit. However, the sum of the Partial Disability Benefit and the salary earned while receiving Partial Disability Benefits may not exceed 100% of Your pre-disability Basic Monthly Earnings. If the total does exceed 100%, then the Partial Disability Benefit will be reduced so that the total will equal 100% of the pre-disability Basic Monthly Earnings.

RECURRENT DISABILITY – Those disabilities which result from the same condition or from a related condition will be treated as one disability and subject to one Maximum Disability Benefit Period unless they are separated by Your return to Active Work for 90 or more consecutive days. Any disability which begins after the termination of this Policy will not be considered a Recurrent Disability and will not be covered by the Policy.

PREGNANCY BENEFIT – Total Disability resulting from pregnancy, complications of pregnancy or child birth is covered the same as any other Sickness. The Elimination Period for the Pregnancy Benefit is calculated from the first date that a Physician diagnoses Total Disability. Total Disability as a result of a normal pregnancy is not covered if the Total Disability begins during the first 9 months following the Effective Date.

GEOGRAPHIC LIMITATION BENEFIT – If You reside outside the United States or its territories during a period of Total Disability or Partial Disability, benefit payments will be limited to the lesser of two Monthly Disability Benefits or Your remaining Maximum Disability Benefit Period. You must first satisfy the Elimination Period.

MAXIMUM DISABILITY BENEFIT PERIOD WHEN YOU REACH AGE 72 – If You are Totally Disabled when you reach age 72 and we have paid benefits for less than the Maximum Disability Benefit Period for such Total Disability, we will continue to pay a monthly benefit during the period of time you remain Totally Disabled for the balance of the Maximum Disability Benefit Period which began prior to the date Your coverage would have normally ended.

BENEFITS (continued)

ALCOHOL OR DRUG ADDICTION LIMITED BENEFIT - If You become Totally Disabled due to alcoholism or drug addiction, We will pay a limited benefit of up to 15 days in any 12-month period after you have satisfied the Elimination Period.

MENTAL OR NERVOUS DISORDER LIMITED BENEFIT – If you become Totally Disabled due to a Mental or Nervous Disorder, benefit payments will be limited to the lesser of three Monthly Disability Benefits or Your remaining Maximum Disability Benefit Period. You must first satisfy the Elimination Period. To qualify for this benefit, You must receive treatment from either:

1. a registered specialist in psychiatry; or
2. a Physician administering treatment on the advice of a registered specialist in psychiatry who certifies that such treatment is medically necessary.

SURVIVOR BENEFIT – If You die while receiving a Monthly Disability Benefit, We will continue the payment of the Benefit to Your Beneficiary. To qualify for this benefit, Total Disability and the payment of the Monthly Disability Benefit must both have continued for at least 12 consecutive months before Your death. Payments under this benefit will terminate on the earlier of:

1. the date that 3 monthly payments have been made to the Beneficiary under this benefit;
2. the date that the Maximum Disability Benefit Period ends; or
3. the date that the Beneficiary dies.

ACCELERATED BENEFIT FOR TERMINAL ILLNESS - We will advance to You the remaining months of the Monthly Disability Benefit payable to You under the Policy in a lump sum payment (not to exceed a maximum of 12 months or your Maximum Benefit Period – whichever is less) if You are diagnosed with a Terminal Illness. You must have satisfied your elimination period and are receiving Total Disability benefits under this policy.

WAIVER OF PREMIUM BENEFIT – If You become Totally Disabled due to a covered Accident or Sickness, Your coverage will be continued for this policy and all attached riders without payment of premium. Waiver of Premium will begin on the later of the next premium due date following:

1. Your satisfaction of the Elimination Period; or
2. 90 days of continuous Total Disability.

Premium must be paid from the beginning of Total Disability to the date that Waiver of Premium begins. Waiver of Premium will continue until the earlier of:

1. The end of Your Total Disability
2. The end of the Maximum Disability Benefit Period
3. The end of the period for which benefits would otherwise be payable; or
4. The date this Policy terminates.

The Waiver of Premium Benefit applies to this policy and all Riders attached to it.

TERMINATION OF BENEFITS – Benefits will automatically end on the earliest of the following:

1. The date that You are no longer considered to be Totally Disabled;
2. The date that You fail to give satisfactory proof of continued Total Disability when requested;
3. Any date that you continue to be Totally Disabled after the end of the Maximum Disability Benefit Period shown on the Policy Specification Page; or
4. Your death, except as provided in the Survivor Benefit.

LIMITATIONS AND EXCLUSIONS

EXCLUSIONS – This Policy does not cover any loss, fatal or non-fatal, which occurs as a result of:

1. Suicide or attempted suicide;
 2. Intentionally self-inflicted injury;
 3. War or any act of war whether declared or undeclared;
 4. Service in the armed forces of any country or authority or units auxiliary thereto (in such event, the pro-rata unearned premium will be returned to you);
 5. Aviation, except as a fare-paying passenger on a scheduled or chartered flight operated by a scheduled airline;
 6. Your participation in a felony, riot or insurrection;
 7. Your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician (the term intoxicated means the blood alcohol content meets or exceeds the legal presumption of intoxicated under the law of the state where the accident occurred);
 8. Alcoholism or drug addiction, except as provided for in the Alcohol or Drug Addiction Limited Benefit;
 9. Mental or Nervous Disorders, except as provided for in the Mental or Nervous Disorder Limited Benefit;
 10. Total Disability while you reside outside the United States or its territories, except as provided for in the Geographic Limitation Benefit;
 11. Normal pregnancy resulting in Total Disability which begins within the first 9 months following the Effective Date;
 12. A Pre-Existing Condition which begins during the Pre-Existing Limitation Period;
 13. Having a work-related injury, unless 24 hour Coverage is shown on the Policy Specification Page;
- and
14. Your being engaged in an illegal occupation.

No benefits are payable during any period in which You are incarcerated.

HOW TO FILE A CLAIM

NOTICE OF CLAIM: Written Notice of Claim must be given to Us within 20 days after any loss covered by this Policy occurs or starts. If notice is not given within that time, it must be given as soon as reasonably possible.

It should include Your name, your address and your Policy number as shown on the Policy Specification Page.

CLAIM FORMS: When We receive the Notice of Claim, We will send the claimant forms for filing Proof of Loss. If these forms are not sent to the claimant within 15 days, the claimant will meet the Proof of Loss requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written Proof of Loss must be given to Us within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

TIME OF PAYMENT OF CLAIMS: Benefits for any loss covered by this Policy will be paid as soon as reasonably possible once We receive proper written proof.

PAYMENT OF CLAIMS: All benefits will be paid to You, Your Beneficiary or Your estate. If benefits are payable to Your estate, We may pay up to \$1,000 to any relative of Yours who We find is entitled to them. Any payment made in good faith will fully discharge Us to the extent of the payment.

Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

If the death of the insured or a covered dependent occurs during a period for which the premium under this Policy has been paid, We will refund the premium or the portion of the premium actually paid by the insured for that person for any period beyond the end of the policy month in which such death occurred.

GENERAL INFORMATION

ENTIRE CONTRACT; CHANGES: This Policy is a legal contract between You and Us. The entire contract consists of the Policy, which includes the application, and any attached papers. No change in this Policy will be effective until approved by the President, a Vice President or an Assistant Vice President of the Company.. This approval must be noted on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two years from the date a person becomes covered under this Policy We cannot use misstatements, except fraudulent misstatements, in Your application to void coverage or deny a claim for loss that happens after the two year period.

The above provisions also apply to riders attached to this Policy. In applying them the word "Rider" will be used for the word "Policy".

LEGAL ACTIONS: You cannot bring a legal action to recover benefits under Your Policy for at least 60 days after You have given Us written proof of loss. You cannot start such an action more than three years after the date proof of loss is required.

GRACE PERIOD: Your premium must be paid on or before the date it is due or during the 31 day grace period that follows. The Policy stays in force during Your Grace Period. This grace period does not apply if You request termination of this Policy.

REINSTATEMENT: If any renewal premium is not paid within the time allowed for payment and We accept a premium without requiring an application for reinstatement, that payment shall reinstate this Policy. If We require an application, this Policy will be reinstated when We approve it. If We do not approve the application, this Policy will be reinstated on the 45th day after the date of the application unless We notify You in writing of its disapproval.

After two years from the date We reinstate this Policy, We cannot use misstatements in Your reinstatement application to void coverage or deny a claim for loss that happens after the two-year period. In all other respects You and We have the same rights under this Policy as We both had before it lapsed, unless special conditions are added to this Policy in connection with the reinstatement. Any premium accepted in connection with this provision will be used for a period for which payment has not been made, but not to any period more than 60 days before the date of reinstatement.

MISSTATEMENT OF AGE: If the Insured's Age has not been stated correctly, an adjustment in premium, coverage, or both, will be made. The adjustment will correct the coverage to what the premium paid would have bought at the Insured Person's true Age. This change will be based on our rates in effect on the Date of Issue.

OTHER INSURANCE WITH US: If You have more than one Disability Income Policy with Us, only one Policy chosen by You will be effective (this includes coverage for any Insured Person). We will cancel the Policy and refund all premiums paid for all other policies in force during the same period of time.

GENERAL INFORMATION (Continued)

CHANGE OF OCCUPATION: If You are injured or contract a sickness after having changed Your occupation to one classified by Us as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, We will pay only such portion of the benefit provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by Us for such more hazardous occupation. If You change Your occupation to one classified by Us as less hazardous than that stated in this policy, We, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro-rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent.

CHANGE OF BENEFICIARY: The beneficiary is named in the application or later endorsement as it applies to the Survivor Benefit. You may change the beneficiary by written request without their consent. This change will take effect on the date the notice is signed. A payment by Us prior to receipt of such change will fully discharge Us to the extent of such payment.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to have any Insured Person examined when and as often as is reasonable during the handling of a claim and do an autopsy where it is not forbidden by law. If We initiate the request, either or both will be done at our expense.

TERM OF COVERAGE: Coverage starts on the Policy Effective Date at 11:59 PM, Standard Time at Your residence address. It ends at 12:01 AM on the same Standard Time on the renewal date, subject to the Grace Period. This Policy may be renewed only as stated in the Renewal Agreement. Each time this Policy is renewed, the new term begins when the old term ends.

TERMINATION OF POLICY: This policy will terminate on the earliest of the following:

1. Written request by you to terminate this policy;
2. Failure to pay the premiums for this policy; subject to the Grace Period allowed;
3. The Policy Anniversary on or next following your 72nd birthday; or
4. Your death.

CHARTER AND BY-LAWS: No provisions of Our charter and by-laws not included in this Policy shall void this Policy or be used in defense of any legal proceedings with regard to it.

POLICY SPECIFICATION PAGE: The Policy Specification Page and information it shows is a part of the Policy.

Endorsements, if any
(To be made by Company only)

GUARANTEED RENEWABLE DISABILITY INCOME INSURANCE POLICY

NON-PARTICIPATING

AMALGAMATED LIFE INSURANCE COMPANY
[333 WESTCHESTER AVENUE WHITE PLAINS, NY 10604]

CATASTROPHIC LOSS RIDER

Amalgamated Life Insurance Company, (herein called We, Our or Us) has issued this Rider as a part of the Policy to which it is attached. The premium You paid and the application You completed have put this Rider in force as of the Rider Effective Date. A copy of Your application is attached.

This Rider is a part of the Policy. All provisions of the Policy not in conflict with the provisions of this Rider apply to this Rider, unless We state otherwise in this Rider.

BENEFITS

The Company will provide to You a Catastrophic Loss Monthly Benefit as shown on the Policy Specification Page if You have a Catastrophic Loss and meet the eligibility requirements as defined under this Rider. Benefits will become payable in the first month following the end of the Catastrophic Loss Elimination Period, when the Company receives Due Proof that the benefit eligibility requirements have been met and have continued throughout the full Catastrophic Loss Elimination Period. If the Catastrophic Loss Monthly Benefit is to be paid for less than a full month, the amount of benefit will be reduced pro-rata on the basis that one day's benefit equals 1/30th of the Catastrophic Loss Monthly Benefit.

Benefit payments under this Rider will end on the earliest of the following dates:

1. the date that You no longer meet the benefit eligibility requirements;
2. the end of the Catastrophic Loss Lifetime Maximum Period shown on the Policy Specification Page; or
3. the date of Your death or the maturity of the Policy.

BENEFIT ELIGIBILITY REQUIREMENTS: In order to meet the eligibility requirements for this benefit, You must:

1. have a Catastrophic Loss, as defined under this Rider;
2. have satisfied the Catastrophic Loss Elimination Period as shown on the Policy Specification Page; and
3. be under the Regular Care and Attendance of a Physician.

Before a Monthly Benefit is paid, the Catastrophic Loss must continue for the full period shown on your Policy Specification Page as the Catastrophic Loss Elimination Period. Benefits will become payable in the first month following the end of the Catastrophic Loss Elimination Period, when the Company receives Due Proof that the benefit eligibility requirements have been met and have continued throughout the full Catastrophic Loss Elimination Period. The Catastrophic Loss Elimination Period begins on the first day after the effective date of the Rider that You are diagnosed by a Physician as having a Catastrophic Loss, as defined under this Rider. The Catastrophic Loss must continue for each subsequent Catastrophic Loss Monthly Benefit to be paid.

DEFINITIONS

The terms used in this Rider are as defined in the Policy ("DEFINITIONS") section. In addition, the following definitions apply to this Rider.

ACTIVITIES OF DAILY LIVING means the basic human functions required for You to remain independent. Activities of Daily Living are as follows:

1. **Continence:** Maintaining control of bladder and/or functions of the bowel, including the ability to use ostomy supplies or other devices such as catheters;
2. **Bathing:** Washing in a bathtub, shower, or other accepted manner, including getting in and out of the bathtub or shower;
3. **Transferring:** Moving between the bed and the chair; or the bed and a wheelchair, with or without assistive device;
4. **Dressing:** Putting on and taking off all necessary items of clothing; and/or medically necessary braces and artificial limbs usually worn;
5. **Toileting:** Getting to and from the toilet; getting on and off the toilet; and performing associated personal hygiene; and
6. **Eating:** Performing all major tasks of getting food into the body, with or without assistive device.

You are considered unable to perform an Activity of Daily Living if the task cannot be performed safely without another person's stand-by assistance or verbal cueing. The inability to perform a task must be generally recognized by the medical profession as a consequence of the disabling Injury or Sickness.

CATASTROPHIC LOSS means that due to an Injury or Sickness you are continuously not able to perform **two (2)** or more Activities of Daily Living.

DUE PROOF means written proof satisfactory to us.

CATASTROPHIC LOSS ELIMINATION PERIOD means the period of time during which no benefits are payable. The Elimination Period is shown on the Policy Specification Page. Monthly Benefits will be payable for the first month following the end of the Catastrophic Loss Elimination Period if we receive due proof that the Catastrophic Loss:

1. continued throughout the full elimination period; and
2. began while this Rider is in force.

INJURY means bodily injury sustained by You, which is the direct cause of the Catastrophic Loss, independent of disease or bodily infirmity; and which occurs while Your coverage under this Rider is in force.

CATASTROPHIC LOSS LIFETIME MAXIMUM PERIOD means the longest period, as shown on the Policy Specification Page, that the Company will make payments to you. Your coverage under this Rider terminates when your benefit payments reach the end of the Catastrophic Loss Lifetime Maximum Period.

CATASTROPHIC LOSS MONTHLY BENEFIT is the amount shown on the Policy Specification Page. For a partial month where You meet the benefit eligibility requirements following the Catastrophic Loss Elimination Period, benefits are payable on a pro-rata basis.

CATASTROPHIC LOSS PRE-EXISTING CONDITION means an Injury or Sickness for which, during a twelve-month period immediately preceding the Effective Date of this Rider, You have received a diagnosis or advice from a Physician and received treatment, incurred medical expenses or taken prescription drugs. The term Pre-Existing Condition shall also include any condition which is related to any such Injury or Sickness.

CATASTROPHIC LOSS PRE-EXISTING LIMITATION PERIOD means the period of time (as shown on the Policy Specification Page) during which no benefits are payable for a Catastrophic Loss Pre-Existing Condition.

PHYSICIAN means a duly licensed practitioner of the healing arts acting within the scope of such license to treat Accidental Injuries or Sickness which results in a Catastrophic Loss. A Physician cannot be You or

anyone related to You by blood or marriage, a business or professional partner, or any person who has a financial affiliation or business interest with You.

REGULAR CARE AND ATTENDANCE means:

1. You personally visit a Physician as often as is medically required to effectively manage and treat the Catastrophic Loss, according to generally accepted medical standards; and
2. You are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the Sickness or Injury causing the Catastrophic Loss must be given by a Physician whose specialty or experience is appropriate.

SICKNESS means illness or disease which starts while Your coverage under this Rider is in force and which is the direct cause of the loss.

YOU OR YOUR means the person named as the Insured on the Policy Specification Page.

TERMINATION

Coverage under this Rider will end on the earliest of the following dates:

1. the date that you request termination of this rider or of the policy it is attached to;
2. the date the Policy lapses or terminates;
3. the end of the last period for which premium payment has been made to Us; or
4. the end of the Catastrophic Loss Lifetime Maximum Period.

Except for voluntary surrender of the Policy this Rider is attached to or the end of the Catastrophic Loss Lifetime Maximum Period, termination of this coverage will not prejudice any payable claim which begins while coverage is in force.

EXCLUSIONS & LIMITATIONS

This Rider does not cover any loss, fatal or non-fatal, which occurs as a result of:

1. Suicide or attempted suicide;
2. Intentionally self-inflicted injury;
3. War or any act of war whether declared or undeclared;
4. Service in the armed forces of any country or authority (in such event, the pro-rata unearned premium will be returned to you);
5. Aviation, except as a fare-paying passenger on a scheduled or chartered flight operated by a scheduled airline;
6. Your participation in a felony, riot or insurrection;
7. Your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician;
8. Mental or Nervous Disorders;
9. A Catastrophic Loss Pre-Existing Condition which begins during the Catastrophic Loss Pre-Existing Limitation Period; and
10. Having a work-related injury, unless 24 hour Coverage is shown on the Policy Specification Page.

No benefits are payable during any period in which You are incarcerated.

GEOGRAPHIC LIMITATION – If You reside outside the United States or its territories during a period of when you have a Catastrophic Loss, benefit payments will be limited to the lesser of two Catastrophic Loss Monthly Benefits or Your remaining Catastrophic Loss Lifetime Maximum Period. You must first satisfy the Catastrophic Loss Elimination Period.

This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them.

Signed for Us at Our Home Office on the Rider Effective Date.

[


President

AMALGAMATED LIFE INSURANCE COMPANY
[333 WESTCHESTER AVENUE WHITE PLAINS, NEW YORK 10604]

PHYSICAL THERAPY BENEFIT RIDER

Amalgamated Life Insurance Company (herein called We, Our or Us) has issued this Rider as a part of the Policy to which it is attached.

The premium You paid and the application You completed has put this Rider in force as of the Rider Effective Date. A copy of Your application is attached. This Rider is a part of the Policy. All provisions of the Policy not in conflict with the provisions of this Rider apply to this Rider, unless we state otherwise in this Rider.

BENEFITS

PHYSICAL THERAPY: We will pay \$50 per day for each day You receive physical therapy treatment as the result of a Covered Accident or Covered Sickness. We will pay a maximum of ten (10) days per period of Disability. You must be receiving Total Disability benefits or Partial Disability benefits under the Policy at the time the physical therapy treatment is provided. All services must be prescribed by a Physician and rendered by a Physical Therapist and performed in an office or in a Hospital on an inpatient or outpatient basis.

DEFINITIONS

The terms used in this Rider are as defined in the Policy ("DEFINITIONS") section. In addition, the following definitions apply to this Rider.

COVERED ACCIDENT means an Injury which:

1. occurs after the Rider Effective Date;
2. occurs while this Rider is inforce;
3. is not excluded by name or specific description in this Rider.

COVERED SICKNESS means an illness, infection, disease or any other abnormal physical condition which is not caused by an Injury and:

1. occurs after the Rider Effective Date;
2. occurs while this Rider is inforce;
3. is not a Pre-Existing Condition; and
4. is not excluded by name or specific description in this Rider.


INJURY for purposes of this Rider, means an accidental bodily injury. The Loss must be a direct result of a bodily injury and is independent of all other causes.

PHYSICAL THERAPIST is a person, other than You or an Immediate Family member, who: (a) is licensed by the state to practice physical therapy; (b) performs services which are allowed by his license; (c) performs services for which benefits are provided by this Policy; and (d) practices according to the Code of Ethics of the American Physical Therapy Association.

PHYSICIAN means a doctor of medicine or an osteopath who is duly licensed by the state medical board. Such person must not be the Primary Insured or any Insured Person's Immediate Family member and must be providing services within the scope of his or her license. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible physicians.

RIDER EFFECTIVE DATE means the date on which coverage under this Rider shall begin. The coverage applied for begins at 11:59 PM on the date the application is signed by You requesting this Rider coverage, provided the Company has approved the issuance of the Rider and has received the required premiums.

Signed for Us at Our Home Office on the Rider Effective Date.

[


President

AMALGAMATED LIFE INSURANCE COMPANY
[333 WESTCHESTER AVENUE WHITE PLAINS, NEW YORK 10604]

CONTINUING DISABILITY BENEFIT RIDER

Amalgamated Life Insurance Company (herein called We, Our or Us) has issued this Rider as a part of the Policy to which it is attached.

The premium You paid and the application You completed has put this Rider in force as of the Rider Effective Date. A copy of Your application is attached. This Rider is a part of the Policy. All provisions of the Policy not in conflict with the provisions of this Rider apply to this Rider, unless we state otherwise in this Rider.

BENEFITS

We will pay the Continuing Disability Monthly Benefit shown on the Policy Specification Page if You are Totally Disabled and have satisfied the Continuing Disability Elimination Period shown on the Policy Specification Page. We will not pay benefits beyond the Continuing Disability Maximum Benefit Period shown on the Policy Specification Page.


The benefits of this Rider are paid in addition to any Monthly Disability Benefit provided in the Policy. You must be receiving Total Disability Benefits under the Policy to be eligible for this benefit.

DEFINITIONS

The terms used in this Rider are as defined in the Policy ("DEFINITIONS") section. In addition, the following definition applies to this Rider.

RIDER EFFECTIVE DATE means the date on which coverage under this Rider shall begin. The coverage applied for begins at 11:59 PM on the date the application is signed by You requesting this Rider coverage, provided the Company has approved the issuance of the Rider and has received the required premiums.

Signed for Us at Our Home Office on the Rider Effective Date.

[


President

AMALGAMATED LIFE INSURANCE COMPANY
[333 WESTCHESTER AVENUE WHITE PLAINS, NEW YORK 10604]

STRIKE WAIVER OF PREMIUM RIDER

Amalgamated Life Insurance Company, (herein called We, Our or Us) has issued this Rider as a part of the Policy to which it is attached.

The premium You paid and the application You completed have put this Rider in force as of the Rider Effective Date. A copy of Your application is attached. This Rider is a part of the Policy. All provisions of the Policy not in conflict with the provisions of this Rider apply to this Rider, unless We state otherwise in this Rider.

BENEFITS – STRIKE WAIVER OF PREMIUM

We will waive premiums on this policy and all attached riders if:

1. We receive notice that You are on Strike for at least 30 days; and
2. You are a dues paying member of the Union shown on the Policy Specification Page; and
3. the Strike starts at least six (6) months after the effective date of this Rider or after the effective date of any reinstatement of this Rider; and
4. the Strike starts while this Rider is in force; and
5. notice of the strike is received by Us within three (3) months of the start of the strike.

Premiums will be waived as of the beginning of the first Policy Month after the start of the strike. Premiums will be waived for up to six (6) months during a period of continuous Strike. If You qualify for this benefit for a period of less than six (6) months and You are on Strike again within two (2) months, the Strike periods will be considered as continuous. Premiums will be waived for a total of six (6) months during any continuous period of Striking. If You cease to be a member of the Union shown on the Policy Specification Page, You may request cancellation of this Rider.


DEFINITIONS

The terms used in this Rider are as defined in the Policy ("DEFINITIONS") section. In addition, the following definitions apply to this Rider.

STRIKE means a lawful primary strike authorized as provided by the union's constitution and by-laws. The Union is shown on the Policy Specification Page.

RIDER EFFECTIVE DATE means the date on which coverage under this Rider shall begin. The coverage applied for begins at 11:59 PM on the date the application is signed by You requesting this Rider coverage, provided the Company has approved the issuance of the Rider and has received the required premiums.

Signed for Us at Our Home Office on the Rider Effective Date.

[

_____]]
President

PART A**Please Use Black Ink****Amalgamated Life Insurance Company (the Company)****[333 Westchester Avenue, White Plains, NY 10604]**Application for
Disability Income Insurance

1. Proposed Insured's Name - Last		First		Middle	
2. Home Address - Street/Box No. City State Zip					Home Phone Number
3. Mailing Address (if different) - Street/Box No. City State Zip					
4. Social Security Number	5. Birthdate (Mo. Day Yr.)	6. Age Last Birthday	7. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	8. State of Birth	
9. Name of Employer			10. Class	11. Occupation	
12. Date of Employment (Mo. Day Yr.) / /	13. Duties		14. Average Monthly Earnings Last 12 Months \$		
15. Are you currently actively at work and able to perform the duties of your occupation? <input type="checkbox"/> YES <input type="checkbox"/> NO					
16. To the best of your knowledge and belief: have you had a: a) heart attack; b) heart bypass; c) coronary artery disease; d) stroke; e) cancer (other than basal or squamous cell skin cancer); and/or f) been treated or diagnosed by a member of the medical profession as having an immune deficiency disorder or AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Have you been hospitalized in the last 90 days (for any reason) or been recommended to seek: a) medical advice; b) treatment; c) care; and/or d) counseling that has not yet been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No					
SELECT THE COVERAGE YOU WANT BY SELECTING FROM BELOW:					
17. BENEFIT PERIOD		19. BENEFITS			WEEKLY PREMIUM
<input type="checkbox"/> 3 month <input type="checkbox"/> 24 month <input type="checkbox"/> 6 month <input type="checkbox"/> 5 years <input type="checkbox"/> 12 month <input type="checkbox"/> _____		Monthly Disability Income: Benefit Amount: \$ _____ Riders: <input type="checkbox"/> Physical Therapy Rider <input type="checkbox"/> Strike Waiver of Premium Rider <input type="checkbox"/> Continuing Disability Rider <ul style="list-style-type: none"> ▪ Elimination Period: 180 days ▪ Benefit Period: <input type="checkbox"/> 6 months <input type="checkbox"/> 18 months ▪ Benefit Amount: \$ _____ <input type="checkbox"/> Catastrophic Loss Rider <ul style="list-style-type: none"> ▪ Elimination Period: <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days ▪ Benefit Period: <input type="checkbox"/> 12 mths <input type="checkbox"/> 24 mths <input type="checkbox"/> 36 mths ▪ Benefit Amount: \$ _____ 			\$ _____ \$ _____ \$ _____ \$ _____ \$ _____ \$ _____
18. ELIMINATION PERIOD		Total Weekly Deduction:			
<input type="checkbox"/> 0/7 days <input type="checkbox"/> 60/60 days <input type="checkbox"/> 7/7 days <input type="checkbox"/> 90/90 days <input type="checkbox"/> 14/14 days <input type="checkbox"/> 180/180 days <input type="checkbox"/> 30/30 days <input type="checkbox"/> _____					
20. Primary Beneficiary _____ Relationship _____ D.O.B. _____					
21. PRESENT INSURANCE: List all disability insurance you now have in force or are applying for with the Company or another company:					
Name of Company	Policy No.	Elimination Period (days)	Benefit Period (Years)	Total Monthly Benefit	Coverage to be Replaced?

ACKNOWLEDGEMENT: I understand and agree that:

- The information in this application will be used to determine my eligibility for insurance; to the best of my knowledge and belief, the statements and answers shown in this application (*first page and, if applicable, the second page*) are true and complete; the Company may rely upon such answers as the basis of my contract; and no coverage will take effect until the application is approved by the Company, the first premium is received, and a Policy is issued.
- "Pre-existing conditions" diagnosed or treated before this coverage takes effect may not be covered; and I should read my Policy for a more detailed explanation of the pre-existing exclusion, if any.
- Insurance effective at any time on you under a like policy with the Company is limited to one such policy elected by the Insured. See the Policy for a more detailed explanation of this provision.
- I have received a copy of the Privacy Notice.
- I authorize my employer to deduct the premium from my wages for remittance to Amalgamated Life Insurance Company to provide the payments required to purchase this insurance coverage. This amount may be adjusted if my coverage or premium is changed.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at _____ (City and State) _____ (Month) (Day) (Year) **X** _____
Proposed Insured's Signature

I, the undersigned agent, certify that: (1) I have personally interviewed the proposed insured; (2) I have accurately recorded the information supplied by the proposed insured.

Dated at _____ (City and State) _____ (Month) (Day) (Year) **X** _____
Agent's Signature

PART B

To be completed when applying for simplified issue.

22. Name of Proposed Insured: _____ Height: _____ Weight: _____

23. To the best of your knowledge and belief:

A. In the past 7 years have you ever had any known indication of or been told that you have:

(1) asthma/emphysema/lung/respiratory disorder or disease; (2) high blood pressure/heart/circulatory/blood disorder or stroke; (3) gastrointestinal/pancreatitis/liver disorder or disease; (4) diabetes; (5) leukemia/cancer/tumor or malignancy/lymphatic disorder or disease; (6) loss of consciousness/epilepsy/mental/nervous/neurological disease or disorder; (7) kidney/genito-urinary/rectal/reproductive/breast disease or disorder; (8) back/muscles/bone/joint disorder or disease; (9) paralysis or polio residuals; (10) lupus; (11) disorder of the eye?

☐ Yes

☐ No

B. In the past 7 years, have you: (1) been hospitalized or had hospitalization recommended; (2) had a physical examination or medical test with other than normal results?

☐ Yes

☐ No

C. Have you used on a regular basis or are you currently using or ever received treatment or consultation for the use of drugs (*prescription or non-prescription*) or alcohol?

☐ Yes

☐ No

D. Are you now taking medication (*prescription or non-prescription*) or under the care of a medical practitioner or chiropractor?

☐ Yes

☐ No

E. Any other medical treatment recommended, but NOT YET completed?

☐ Yes

☐ No

24. Details for questions 23 A, B, C, D or E answered "Yes". Include question number.

Name	Disease or Injury	Date	Details

SERFF Tracking Number: AMAL-126854778 State: Arkansas

Filing Company: Amalgamated Life Insurance Company State Tracking Number: 47754

Company Tracking Number: AMINDDI-10

TOI: H111 Individual Health - Disability Income Sub-TOI: H111.006 Short Term - Related to marketing with employer or association groups

Product Name: Individual Disability Income

Project Name/Number: Individual Disability Income/AMINDDI-10

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 01/21/2011	Individual Disability Income Rates	AMINDDI-10, AMINDDI-CATLOSSR-10, AMINDDI-CONTDIR-10, AMINDDI-PTR-10, AMINDDI-STRICKER-10	New		ALICO DI Rates only.pdf

Policy Form AMINDDI-10

Rate Exhibit 1

1. Non-Occupational – Unisex Annual Premium per \$100 Monthly Benefit

Benefit Period	3 Months							6 Months						
Elimination Period (Accident / Sickness)	00/07	07/07	14/14	30/30	60/60	90/90	180/180	00/07	07/07	14/14	30/30	60/60	90/90	180/180
Class AAA														
18-29	36.01	34.02	24.42	13.30	9.45	3.67	3.23	43.83	41.51	30.08	17.66	12.93	5.84	5.14
30-39	36.01	34.02	24.42	13.30	9.45	3.67	3.23	43.83	41.51	30.08	17.66	12.93	5.84	5.14
40-49	36.01	34.02	24.42	13.30	9.45	3.67	3.23	43.83	41.51	30.08	17.66	12.93	5.84	5.14
50-59	39.24	35.67	26.01	15.92	12.58	7.57	6.66	50.83	46.90	34.85	22.99	18.74	12.36	10.88
60+	48.03	41.26	35.20	24.77	20.20	13.34	11.74	64.33	57.00	49.68	36.83	30.98	22.22	19.55
Class AA														
18-29	41.69	39.16	28.78	16.89	12.27	5.35	4.71	49.65	47.94	35.61	22.65	16.99	8.51	7.49
30-39	41.69	39.16	28.78	16.89	12.27	5.35	4.71	49.65	47.94	35.61	22.65	16.99	8.51	7.49
40-49	41.69	39.16	28.78	16.89	12.27	5.35	4.71	49.65	47.94	35.61	22.65	16.99	8.51	7.49
50-59	43.44	39.34	29.84	19.84	15.93	10.06	8.85	56.46	51.88	39.98	28.65	23.76	16.42	14.45
60+	53.42	47.05	35.89	28.27	23.12	15.40	13.55	72.13	65.24	50.64	42.05	35.48	25.63	22.56
Class A														
18-29	47.57	44.72	35.76	22.11	16.58	8.29	7.30	57.02	54.95	44.49	29.89	23.21	13.18	11.60
30-39	47.57	44.72	35.76	22.11	16.58	8.29	7.30	57.02	54.95	44.49	29.89	23.21	13.18	11.60
40-49	47.57	44.72	35.76	22.11	16.58	8.29	7.30	57.02	54.95	44.49	29.89	23.21	13.18	11.60
50-59	49.05	44.63	36.70	26.23	21.34	13.99	12.32	64.03	59.08	49.31	37.91	31.89	22.85	20.11
60+	60.78	53.97	44.30	34.89	29.74	22.02	19.38	82.92	75.45	62.89	51.95	45.83	36.64	32.24
Benefit Period	12 Months							24 Months						
Elimination Period (Accident / Sickness)	00/07	07/07	14/14	30/30	60/60	90/90	180/180	00/07	07/07	14/14	30/30	60/60	90/90	180/180
Class AAA														
18-29	55.20	52.41	38.38	25.02	18.96	9.86	8.68	68.66	65.35	48.41	31.94	24.91	14.37	12.64
30-39	55.20	52.41	38.38	25.02	18.96	9.86	8.68	68.66	65.35	48.41	31.94	24.91	14.37	12.64
40-49	55.20	52.41	38.38	25.02	18.96	9.86	8.68	68.66	65.35	48.41	31.94	24.91	14.37	12.64
50-59	70.12	65.41	49.61	36.34	30.64	22.09	19.44	97.97	92.22	71.28	52.01	45.08	34.68	30.52
60+	94.25	85.48	76.06	61.19	53.13	41.03	36.11	140.51	129.60	117.18	91.73	81.40	65.90	57.99
Class AA														
18-29	64.32	60.71	45.60	32.37	25.17	14.37	12.64	80.17	75.88	57.65	41.47	33.24	20.88	18.38
30-39	64.32	60.71	45.60	32.37	25.17	14.37	12.64	80.17	75.88	57.65	41.47	33.24	20.88	18.38
40-49	64.32	60.71	45.60	32.37	25.17	14.37	12.64	80.17	75.88	57.65	41.47	33.24	20.88	18.38
50-59	77.99	72.48	56.80	45.21	38.85	29.32	25.80	109.10	102.33	81.39	64.65	57.18	45.99	40.47
60+	106.14	97.94	77.38	69.84	60.84	47.33	41.65	158.73	148.60	119.05	104.66	93.20	76.01	66.89
Class A														
18-29	73.82	69.77	57.25	43.04	34.72	22.24	19.57	92.16	87.38	72.63	55.33	46.09	32.22	28.35
30-39	73.82	69.77	57.25	43.04	34.72	22.24	19.57	92.16	87.38	72.63	55.33	46.09	32.22	28.35
40-49	73.82	69.77	57.25	43.04	34.72	22.24	19.57	92.16	87.38	72.63	55.33	46.09	32.22	28.35
50-59	88.65	82.69	70.13	59.82	52.21	40.78	35.89	124.21	116.90	100.63	85.55	76.93	64.00	56.32
60+	122.74	113.74	96.40	86.33	78.87	67.69	59.57	184.33	173.08	148.64	129.44	121.16	108.74	95.69
Benefit Period	60 Months													
Elimination Period (Accident / Sickness)	00/07	07/07	14/14	30/30	60/60	90/90	180/180							
Class AAA														
18-29	81.94	78.32	59.00	43.52	34.99	22.19	19.53							
30-39	81.94	78.32	59.00	43.52	34.99	22.19	19.53							
40-49	81.94	78.32	59.00	43.52	34.99	22.19	19.53							
50-59	143.18	135.96	107.02	85.25	75.60	61.12	53.79							
60+	199.92	186.43	169.59	139.31	125.06	103.68	91.24							
Class AA														
18-29	95.72	90.99	70.23	56.57	46.77	32.07	28.22							
30-39	95.72	90.99	70.23	56.57	46.77	32.07	28.22							
40-49	95.72	90.99	70.23	56.57	46.77	32.07	28.22							
50-59	159.58	151.05	121.98	105.89	95.94	81.02	71.29							
60+	225.89	213.41	172.76	159.16	143.46	119.92	105.53							
Class A														
18-29	110.17	104.94	88.76	75.63	65.03	49.14	43.24							
30-39	110.17	104.94	88.76	75.63	65.03	49.14	43.24							
40-49	110.17	104.94	88.76	75.63	65.03	49.14	43.24							
50-59	182.00	172.81	150.97	140.15	129.18	112.74	99.21							
60+	262.48	248.52	215.51	196.91	186.47	170.81	150.31							

Rate Exhibit 2

Benefit Period	3 Months							6 Months						
Elimination Period (Accident / Sickness)	00/07	07/07	14/14	30/30	60/60	90/90	180/180	00/07	07/07	14/14	30/30	60/60	90/90	180/180
Class AAA														
18-29	46.51	43.03	30.45	16.52	11.77	4.63	4.08	56.80	52.75	37.71	22.13	16.23	7.37	6.49
30-39	46.51	43.03	30.45	16.52	11.77	4.63	4.08	56.80	52.75	37.71	22.13	16.23	7.37	6.49
40-49	46.51	43.03	30.45	16.52	11.77	4.63	4.08	56.80	52.75	37.71	22.13	16.23	7.37	6.49
50-59	51.96	45.72	32.94	20.14	15.85	9.43	8.30	66.76	59.87	44.00	29.01	23.56	15.38	13.53
60+	64.22	52.38	44.15	30.91	25.20	16.64	14.64	84.70	71.87	62.01	45.80	38.56	27.68	24.36
Class AA														
18-29	54.53	50.09	36.70	21.62	15.78	7.01	6.17	66.81	61.58	45.64	29.21	21.98	11.14	9.81
30-39	54.53	50.09	36.70	21.62	15.78	7.01	6.17	66.81	61.58	45.64	29.21	21.98	11.14	9.81
40-49	54.53	50.09	36.70	21.62	15.78	7.01	6.17	66.81	61.58	45.64	29.21	21.98	11.14	9.81
50-59	57.97	50.79	38.38	25.46	20.36	12.71	11.19	74.71	66.69	51.24	36.67	30.30	20.74	18.25
60+	71.45	60.30	45.77	35.65	29.14	19.37	17.04	95.05	83.00	64.17	52.80	44.56	32.20	28.34
Class A														
18-29	62.87	57.89	45.98	28.88	21.86	11.34	9.98	77.24	71.39	57.44	39.28	30.77	18.01	15.85
30-39	62.87	57.89	45.98	28.88	21.86	11.34	9.98	77.24	71.39	57.44	39.28	30.77	18.01	15.85
40-49	62.87	57.89	45.98	28.88	21.86	11.34	9.98	77.24	71.39	57.44	39.28	30.77	18.01	15.85
50-59	65.86	58.13	47.46	33.99	27.63	18.08	15.91	85.26	76.60	63.52	48.99	41.19	29.49	25.95
60+	81.30	69.39	56.54	44.49	37.82	27.82	24.48	109.37	96.28	79.76	65.93	58.05	46.23	40.68
Benefit Period	12 Months							24 Months						
Elimination Period (Accident / Sickness)	00/07	07/07	14/14	30/30	60/60	90/90	180/180	00/07	07/07	14/14	30/30	60/60	90/90	180/180
Class AAA														
18-29	71.74	66.84	48.34	31.59	23.93	12.45	10.96	89.32	83.53	61.14	40.44	31.51	18.11	15.94
30-39	71.74	66.84	48.34	31.59	23.93	12.45	10.96	89.32	83.53	61.14	40.44	31.51	18.11	15.94
40-49	71.74	66.84	48.34	31.59	23.93	12.45	10.96	89.32	83.53	61.14	40.44	31.51	18.11	15.94
50-59	91.42	83.19	62.44	45.73	38.43	27.47	24.17	126.95	116.89	89.46	65.33	56.43	43.09	37.92
60+	122.47	107.14	94.49	75.88	65.96	51.07	44.95	180.82	161.72	145.12	113.53	100.92	82.00	72.16
Class AA														
18-29	84.57	78.24	58.70	41.99	32.71	18.80	16.54	105.46	97.95	74.36	53.90	43.25	27.27	24.00
30-39	84.57	78.24	58.70	41.99	32.71	18.80	16.54	105.46	97.95	74.36	53.90	43.25	27.27	24.00
40-49	84.57	78.24	58.70	41.99	32.71	18.80	16.54	105.46	97.95	74.36	53.90	43.25	27.27	24.00
50-59	102.45	92.80	72.52	57.69	49.41	36.99	32.55	142.38	130.55	1				

Policy Form AMINDDI-10
Riders Rate Exhibit

1. Continuing Disability Benefit Rider – Premiums are identical to base policy.
2. Physical Therapy Benefit Rider – 2% of the base policy premiums.
3. Catastrophic Loss Rider –

Benefit Period	12 Months		24 Months		36 Months	
Elimination Period	90 Days	180 Days	90 Days	180 Days	90 Days	180 Days
Class AAA						
18-29	0.94	0.86	1.57	1.44	2.06	1.90
30-39	0.94	0.86	1.57	1.44	2.06	1.90
40-49	0.94	0.86	1.57	1.44	2.06	1.90
50-59	2.80	2.55	4.66	4.24	6.01	5.49
60+	7.26	6.57	11.86	10.66	14.25	12.84
Class AA						
18-29	1.25	1.14	2.10	1.92	2.75	2.53
30-39	1.25	1.14	2.10	1.92	2.75	2.53
40-49	1.25	1.14	2.10	1.92	2.75	2.53
50-59	3.73	3.40	6.22	5.65	8.01	7.32
60+	9.68	8.76	15.81	14.22	18.99	17.12
Class A						
18-29	1.87	1.71	3.15	2.87	4.12	3.79
30-39	1.87	1.71	3.15	2.87	4.12	3.79
40-49	1.87	1.71	3.15	2.87	4.12	3.79
50-59	5.60	5.09	9.33	8.48	12.01	10.97
60+	14.52	13.13	23.71	21.33	28.49	25.68

4. Strike Waiver of Premium Rider – 2% load to total premium rates.

<i>SERFF Tracking Number:</i>	<i>AMAL-126854778</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Amalgamated Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47754</i>
<i>Company Tracking Number:</i>	<i>AMINDDI-10</i>		
<i>TOI:</i>	<i>H111 Individual Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H111.006 Short Term - Related to marketing with employer or association groups</i>
<i>Product Name:</i>	<i>Individual Disability Income</i>		
<i>Project Name/Number:</i>	<i>Individual Disability Income/AMINDDI-10</i>		

Supporting Document Schedules

	Item Status:	Status
		Date:
Satisfied - Item: Flesch Certification	Approved-Closed	01/21/2011
Comments:		
Attachment:		
Flesch Certificate AR.pdf		

	Item Status:	Status
		Date:
Satisfied - Item: Application	Approved-Closed	01/21/2011
Comments:		
The application is attached under the Form Schedule tab.		

	Item Status:	Status
		Date:
Satisfied - Item: Outline of Coverage	Approved-Closed	01/21/2011
Comments:		
Attachment:		
outline of coverage (AR).pdf		

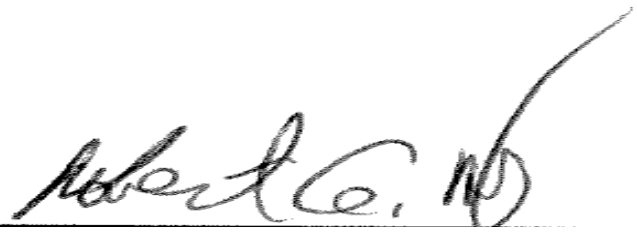
AMALGAMATED LIFE INSURANCE COMPANY
333 Westchester Avenue
White Plains, NY 10604

CERTIFICATION

Amalgamated Life Insurance Company has reviewed the enclosed forms(s) and certifies that to the best of its knowledge and belief, the form(s) meet(s) the minimum flesch scale readability requirements of your State.

<u>FORM</u>	<u>SCORE</u>
AMINDDI-10 (AR)	46.8
AMINDDI-APP-10 (AR)	45.9
AMINDDI-CATLOSSR-10 (AR)	45.9
AMINDDI-CONTDIR-10 (AR)	45.4
AMINDDI-PTR-10 (AR)	57.4
AMINDDI-STRIKER-10 (AR)	52.7

Date: 10/13/10

By: 

AMALGAMATED LIFE INSURANCE COMPANY
333 WESTCHESTER AVENUE
WHITE PLAINS, NY 10604

**DISABILITY INCOME PROTECTION COVERAGE
REQUIRED OUTLINE OF COVERAGE**

- (1) *Read Your Policy Carefully*--This outline provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!
- (2) *Disability Income Protection Coverage*--Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is *not* provided for basic hospital, basic medical surgical, or major-medical expenses.
- (3) The following is a brief description of the benefits contained in *this policy*:
 1. Guaranteed Renewable to age 72.
 2. Coverage [24 hour], [off-the-job only]
 3. Elimination Period
sickness: [0, 7, 14, 30, 60, 90, 180] days
accident: [7, 14, 30, 60, 90, 180] days
 4. Benefit Period: [3 months, 6 months, 12 months, 24 months & 60 months]
 5. The Survivor Benefit Pays 3 months of benefits upon your death if you die while receiving total disability benefits.
 6. The Mental Illness Benefit pays up to 3 months of total disability due to mental illness.
 7. The Alcohol/Drug Benefit pays for up to 15 days in any 12-month period for total disability due to alcoholism or drug addiction. The elimination period applies.
 8. The Company may change rates, but only by class. The new rates must be approved by the Insurance Department prior to use.
 9. There is a Pre-Existing condition limitation of 12 months prior and 12 months following the effective date.
 - [10. The optional Physical Therapy Benefit Rider provides \$50 per day for each day you receive physical therapy treatment as the result of a Covered Accident or Covered Sickness. We will pay a maximum of 10 days per period of Disability. You must be receiving Total Disability or Partial Disability benefits under this policy at the time of physical therapy treatment is provided.]
 - [11. The optional Continuing Disability Benefit Rider pays an additional monthly disability benefit of [\$100] after a 180 day elimination period for [6 months].]
 - [12. The optional Catastrophic Loss Rider pays [\$1,000] with a [90 day] elimination period.]
 - [13. The optional Strike Waiver of Premium Rider provides waiver of premium if you are on strike for [6 months].]
- (4) Exclusions – This Policy does not cover any loss, fatal or non-fatal, which occurs as a result of:
 1. Suicide or attempted suicide;
 2. Intentionally self-inflicted injury;
 3. War or any act of war whether declared or undeclared;
 4. Service in the armed forces of any country or authority or units auxiliary thereto (in such event, the pro-rata unearned premium will be returned to you);
 5. Aviation, except as a fare-paying passenger on a scheduled or chartered flight operated by a scheduled airline;
 6. Your participation in a felony, riot or insurrection;

7. Your being intoxicated or under the influence of any narcotic unless administered on the advice of a physician (the term intoxicated means the blood alcohol content meets or exceeds the legal presumption of intoxicated under the law of the refers to that condition as defined by the laws of the state where the accident occurred;
8. Alcoholism or drug addiction, except as provided for in the Alcohol or Drug Addiction Limited Benefit;
9. Mental or Nervous Disorders, except as provided for in the Mental or Nervous Disorder Limited Benefit;
10. Total Disability while you reside outside the United States or its territories, except as provided for in the Geographic Limitation Benefit;
11. Normal pregnancy resulting in Total Disability which begins within the first 9 months following the Effective Date;
12. A Pre-Existing Condition which begins during the Pre-Existing Limitation Period;
13. Having a work-related injury, unless 24 hour Coverage is shown on the Policy Specification Page; and
14. Your being engaged in an illegal occupation.

No benefits are payable during any period in which You are incarcerated.

- (5) This policy is Guaranteed Renewable to age 72. We may change rates, but only by class. The new rates must be approved by the Insurance Department prior to use. Benefits will automatically end on the earliest of the following: (1) the date that you are no longer considered to be totally disabled; (2) the date that You fail to give satisfactory proof of continued total disability when requested; (3) any date that you continue to be totally disabled after the end of the maximum disability benefit period; or (4) your death, except as provided in the Survivor Benefit.

If you are not satisfied with this policy, you may return it to us within thirty (30) days after you have received it. We will refund your money and the policy will be considered to have never been in force.